Sexuality and Cancer: Conversation Comfort Zone

RICHARD T. PENSON, JOAN GALLAGHER, MARIE ELENA GIOIELLA, MARIA WALLACE, KAREN BORDEN, LINDA A. DUSKA, JAMES A. TALCOTT, FRANK J. MCGOVERN, LEONARD J. APPLEMAN, BRUCE A. CHARNER, THOMAS J. LYNCH, JR.

The Kenneth B. Schwartz Center at Massachusetts General Hospital, Hematology-Oncology Department, Boston, Massachusetts, USA

Key Words: Sexuality · Cancer · Psychosocial

ABSTRACT

Shortly before his death in 1995, Kenneth B. Schwartz, a cancer patient at Massachusetts General Hospital (MGH), founded The Kenneth B. Schwartz Center at MGH. The Schwartz Center is a nonprofit organization dedicated to supporting and advancing compassionate health care delivery, which provides hope to the patient, support to caregivers, and encourages the healing process. The center sponsors the Schwartz Center Rounds, a monthly multidisciplinary forum where caregivers reflect on important psychosocial issues faced by patients, their families, and their caregivers, and gain insight and support from fellow staff members.

Psychosocial issues profoundly affect patients with cancer. Of the many complexities that make up the psychosocial dynamic, perhaps the medical profession is most uncomfortable with sexuality. Many elements of sexual behavior remain high-profile taboos. A number of diseases and treatments significantly affect sexual function. Male and female sexuality were discussed in two separate rounds with an emphasis on how to begin a dialogue about sexuality without jeopardizing other aspects of the relationship with patients. Three cases were presented. A patient with prostate cancer considering treatment options for early-stage disease and two patients with gynecologic malignancies; one with a colostomy following cytoreductive surgery for ovarian cancer and the other with a failed vaginal reconstruction for recurrent squamous cell carcinoma of the vagina. Staff discussed the wide diversity of response to sexual dysfunction and the difficulties that patients face. A sensitive and informed approach to discussing sexuality can provide effective support. The elements of successful dialogue are presented in the PLISSIT model. The Oncologist 2000;5:336-344

PRESENTATION OF CASE: MALE SEXUALITY

Male Sexuality

Mr. A is a 70-year-old man who has had nocturia for approximately two years. Prostatic specific antigen (PSA) was initially measured at 2.7 ng/ml, but rose over a period of approximately two years to 3.5 ng/ml and then 4.5 ng/ml. Transrectal biopsy performed in 1999 was negative for cancer. Repeat PSA in March of this year was 5.0 ng/ml. Repeat biopsy was performed which revealed a single microscopic focus of Gleason six prostate cancer in the left lobe of the prostate and chronic active prostatitis on the right. The urologist recommended radical prostatectomy for this vigorous gentleman with organ-confined disease. The patient was to be seen at this hospital to consider radiation therapy as another option. However, he suffered a myocardial infarction and with persistent angina required angioplasty and stenting. Subsequently he has been pain-free. His
past medical history is of clinical benign prostatic hypertrophy and gastroesophageal reflux disease. He had never smoked and rarely drinks alcohol. He is a retired mechanical engineer and has two grown children. His mother and father both died of myocardial infarctions. His mother had a bone tumor of uncertain origin and two uncles had esophageal cancer. There was no family history of prostate cancer. The patient was a well-appearing youthful gentleman with an unremarkable clinical examination. He was sexually active, had erections that were satisfactory for intercourse and maintained great interest in sexual relations. Potency became a major factor in his decision about treatment options.

The various therapeutic options available to him were discussed. Radical prostatectomy would ordinarily be considered in a patient with organ-confined prostate cancer. However, his recent myocardial infarction increases the risk of elective surgery. The typical side effects of impotence and incontinence with both surgery and radiation therapy were discussed with Mr. A. Given that he has low-grade and likely organ-confined disease, no immediate therapy was discussed as a reasonable option and this was chosen by Mr. A. What impressed the clinicians was how frankly the patient articulated the concept of competing mortality. He reasoned that it was quite possible that he would be dead of cardiac disease before he suffered significant morbidity or died from prostate cancer, an analytical approach that reflected his professional life as an engineer.

**Of the many complexities that make up the psychosocial dynamic, perhaps the medical profession is most uncomfortable with sexuality.**

**DIALOGUE: MALE SEXUALITY**

**Establishing a Dialogue**

**Facilitator:** How did you bring up the issue of sexual function?

**Presenter:** It really came out of questions about genitourinary function. But, Mr. A was explicitly worried about sexual function. Sexuality is usually more of a subtext in these discussions early on and then I ask specifically about erectile function.

**Physician:** Whether patients always give us an accurate answer is not clear. Usually these consultations are with the man and the wife present, they are awkward and often the husband and wife don’t agree. We don’t really feel comfortable with bringing up the subject of erectile dysfunction, and everyone tends to operate on the unspoken assumption that everything is okay down there. This was examined in the pilot study in which we asked about the effect of nerve-sparing prostatectomy on erectile function. What we found was that, before surgery, approximately one-third of men had impotence or an erection that was not firm enough to complete intercourse [1]. Either they hadn’t spoken frankly to their urologist or they were hoping that the nerve-sparing surgery would improve their potency.

**Urologist:** When I first started in practice, my ears turned bright red just with the mention of the word sex. But, doing this kind of surgery it’s absolutely critical because it weighs into the decision-making for the patient. These discussions should take place with their significant other and you just have to bring it up. I usually see the patient with his wife privately in my office. I take a formal history and ask them about their sexual activity and how they feel about it.

**Facilitator:** I’m interested that you always have the wife there. Do you find that women find this easier to talk about?

**Urologist:** The best thing about having the wife there is that in the man’s mind this is a big issue. They are worried that they are going to disappoint their wife. It’s really helpful for the man to hear from the wife that the most important issue is to see the husband alive and well and that the relationship is more than the physical act in sexual relations. For the clinician, the wife is the ally in making it easier for the patient. Wives tend to see it in a totally different light. They’ll give their husbands a backhand and say, “What? Are you crazy. This is cancer. I just want you alive.” It’s important and has to be discussed early.

**Clinical Nurse Specialist:** Over the years I’ve changed in my approach to couples. Now, I almost invariably try to interview each one alone so that I get a feel for what the real issues are for each individual and then talk with them together. So often they have such varying perspectives on the same problem.

**Facilitator:** How do we begin a dialogue in taking a sexual history?

**Physician:** One thing I found helpful was the comment of a community physician about how unhelpful open-ended
questions can be. It is really important to introduce low-risk issues as specific questions and to cover all the possibilities. For example, ask, “Is sex important to you and your partner?”

**Urologist:** I think that timing is everything. Like the burning building situation, I bring it up and deal with it in depth at the time when the therapeutic decision is being made. Then, at the time of surgery, I don’t go back in again. But, later when they’ve recovered, I address it again.

**Physician:** It’s sometimes easier to raise issues of sexual function as part of the routine history linked to urological symptoms or to relationships or to the complications of treatment.

**Understanding Patient and Partner**

**Urologist:** Men are from another planet. They really are. Even the oldest patients, walking to the door with their cane, will turn and ask, “Can I have some of that Viagra?” When you’re discussing postoperative complications, men tend to dismiss every serious complication. But damage to their sexual function really hits them. It really affects who they are. I usually discuss it in a positive light and discuss some of the newer options for treatment of erectile dysfunction. Its easier to talk about a difficult topic if there’s a treatment available. I quote them statistics but encourage them that treatment is available if they have erectile difficulty.

**Urologist:** The diagnosis of a life-threatening illness can precipitate erectile dysfunction, and patients should be encouraged that treatment is very effective.

**Social Worker:** I think it’s really important to be aware of your own feelings about sexuality. Particularly for men, value is wrapped up in penile potency. Many men struggle with this. To be able to open the door to discuss this and make people aware that you’re available if they want to talk, is really important.

**Clinical Nurse Specialist:** What about the situation when the partner isn’t the spouse? What about other choices in sexual orientation?

**Physician:** I don’t think it changes much. In one of the questionnaires, we asked people to comment on how their relationships had been changed, both positively and negatively. When the old paradigm of sexual intercourse is no longer possible, couples have to enrich their relationship in other ways, and this often happens.

**It’s really helpful to have the partner involved and without that it’s a real handicap.**

**Urologist:** I’ve done about 10 radical prostatectomies on gay males and the issues were almost identical.

**Social Worker:** Cultural differences may also strongly influence a patient’s response to loss of sexual function. It is really important for us to be sensitive to different expectations. If there is an area that we’re not comfortable talking about with patients, that’s not an excuse. We have to take the first step, to open the door.

**Female Physician:** I’ve noticed that some men really find it hard to discuss these issues with a female physician.

**Urologist:** Yes, one man said to me, “I had to undress for that lady doctor?” They would never say “man doctor.” I think it is a patient bias and it is likely to change over the next 10 or 20 years.

**Outcome**

**Physician:** In researching the impact of therapy for prostate cancer, it’s clear that there is little appreciation for how much morbidity there is. There are few really good data and a huge amount of ingrained bias. There’s probably a very similar amount of impotence and incontinence after radiotherapy as there is after radical prostatectomy. One thing we have helpfully done in our research and in the multidisciplinary clinic is to give patients a sense of what to expect and how to weigh their choices.

**Urologist:** In outcomes studies the effects of radiation and surgery are similar. Perhaps there is even a little more early morbidity with surgery. Yet, surgeons seem to present a positive impression to patients who fear for their lives. I have to agree. I know that I am prone to that same bias.

**Presentation of Cases: Female Sexuality**

*Ms. B* is a 58-year-old married woman who presented with diarrhea and back pain. Following a normal sigmoidoscopy, she had computerized tomography scans that showed a pleural effusion, ascites, a pelvic mass and infiltration of the omentum. She rapidly became breathless with a large right pleural effusion, and at thoracentesis, the aspirate was cytologically positive for adenocarcinoma. CA-125 was 959 U/ml, and she underwent exploratory laparotomy with optimal cytoreduction of a large pelvic mass and bowel resection with colostomy. Multiple tumor specimens were banked to allow her participation in an autologous tumor vaccine protocol. There was a thin film of persistent disease on her diaphragm at the conclusion of the procedure, and postoperatively intercostal tube drainage was required for continued symptomatic effusion.
Her past medical history is positive for benign breast disease and she had taken hormone replacement therapy. She is a married medical administrator and has a very supportive family. She clearly found the rigors of the devastating diagnosis and medical interventions difficult to accept, describing herself initially as in a state of shock. However, she rapidly adjusted and has been actively involved in all of her treatment decisions. She is a pragmatic person who is in touch with both her feelings and concerns about her present situation. Prior to the diagnosis of cancer, she experienced superficial dysparunia, which has hampered her sexual rehabilitation. She is not having sexual intercourse, which she blames on the colostomy. Staff have talked, at length, about issues relating to the colostomy, which she clearly abhors. Despite this she is able to raise a thin smile and to talk lucidly about how it impacts her self-image and sexuality.

Ms. C is a 42-year-old woman with a long-standing history of squamous cell carcinoma of the vulva and vagina. She was first diagnosed in 1990, at which time she underwent a wide local excision with laser treatment. Her past medical history is significant only for a breast biopsy and appendectomy. She had a recurrence in 1991, which required surgical debridement and adjuvant 5-fluorouracil chemotherapy. In 1993 she again had a recurrence for which she underwent further debridement. She was then lost to follow-up until 1997 when she presented with vaginal bleeding. Biopsies at that time demonstrated microinvasive carcinoma of the right vaginal wall, and she received external beam radiotherapy with a brachytherapy boost. Within a year she had recurrent disease and underwent radical surgery, including removal of uterus, fallopian tubes and ovaries, as well as the vagina and rectum with formation of a permanent colostomy and a colonic neo-vagina. Postoperatively she had excessive wound drainage, which appeared to resolve prior to hospital discharge. However, Ms. C returned to the hospital with urinary retention. She was catheterized and taught intermittent self-catheterization. A few months later it became apparent that she thought that catheterization would be sufficient for vaginal dilatation and had given up using vaginal dilators. Clinical examination revealed woody fibrosis of her introitus that would only admit a pediatric speculum. She was referred to the plastic surgeon but further surgery was thought to be impractical. She became profoundly depressed complaining that the only form of sexual expression that was acceptable to her husband was penetrative vaginal intercourse. She was tearful and despairing and said that she had no interest in living, if she couldn’t be “fixed.”

Ms. C is a very pleasant unassuming woman. She is a skilled pet groomer who also enjoys quilting. She is the devoted mother of two sons who are in high school. Although she acknowledged that she has a strained relationship with her husband, who is verbally abusive when intoxicated, she said that prior to vaginal reconstructive surgery they had enjoyed sexual intercourse. In fact, she described intercourse as the best part of their relationship.

The plastic surgeon that consulted on Ms. C’s case felt that in view of the strong relationship with her surgeon, he should be the one to break the news that further vaginal reconstruction was not possible. The possibility of further surgery was left open but discussing the issues in depth appeared to help her adjust.

**Dialogue: Female Sexuality**

**Opening Dialogue**

**Facilitator:** How do you address issues of sexuality with patients?

**Gynecologic Oncologist:** You have to ask, because patients won’t volunteer sexual issues spontaneously. I see a lot of patients who have problems with intimacy with their partner, whether or not they’ve had surgery or have a colostomy.

**Chemotherapy Nurse:** It’s really important that you give them permission that it’s okay to talk about it.

**Gynecologic Oncologist:** It’s not just gynecologic surgery that causes these issues. Postmastectomy on tamoxifen, these issues of sexual identity and one’s sense of self are very, very important.

**Social Worker:** What’s really good is that you clearly communicate to the patients that you accept their sexual concerns as a perfectly normal aspect of their treatment and rehabilitation. Do you think that as a cancer center we ask enough? For example, of the elderly?

**Chemotherapy Nurse:** I ask at every age. I’ve had some funny answers. One lady said that she was a nun (laugh), which I didn’t know!

**Chemotherapy Nurse:** One of the things that can break the ice is that when I meet them for the first time, along with all of the information and literature, I give them a book on sexuality. That opens it up for discussion.

**Chemotherapy Nurse:** We have some really good literature that we can give out and that I often use to prompt
patients and to show that it’s okay to talk about sex. We talk about a lot of intimate issues when we are giving chemotherapy. It is important to ensure privacy. This is a very intimate issue and hard for some patients to discuss. We need to be explicitly supportive and nonjudgmental.

Nurse: Working in the Gillette Center for Women’s Cancers, I don’t find it difficult to talk about the subject. I ask, “Are you sexually active?” or “Do you have any concerns about sexual intercourse or your sexuality?”

Gynecologic Oncologist: It’s important to be aware of what cancer treatments do to people, so that you can ask directed questions. For example, every woman on tamoxifen will have a vaginal discharge and dryness. If you ask about that, it can lead you into other things like, do you have intercourse with your husband and what lubricants do you use. I ask everyone about their family and their children. I’m nosey and that’s an interest of mine. I talk about contraception. I talk to people about sexually transmitted diseases and any of these things can lead to discussing sex.

Social Worker: I have a lot of patients who appreciate that a male physician asks and considers them as a whole person. But there are women who really don’t want a male doctor asking whether their relationship with their husband is “good” and prefer that the doctor not ask. It’s very variable.

Chemotherapy Nurse: I think it’s much easier if one-on-one you are talking to someone of the same gender.

Nurse: Yes, male doctors are at a real disadvantage by virtue of their sex, and patients do really try to minimize their concerns and can be really embarrassed.

Nurse: Ms. C really is a delightful patient. I want to give her so much. One of the things that has helped me has been to put myself in their shoes. For me, as a woman, that would be a big issue for me. If this person is coming to you for advice, they want someone like them to give advice. It isn’t easy and sometimes we laugh because we’re stuck for words, but we have to discuss dilators and intimacy.

Physician: How can we reach out to the partner when they don’t seem to be involved?

Social Worker: I think we have to take the lead from the patient and not make assumptions. Many of us make the assumption that if people are in marital relationships, they are happy and things are fine. That’s a bad assumption that many of us get tripped up on. At the other extreme we should screen for domestic violence. If a woman doesn’t want their partner in the room, there’s usually a good reason for that and we should be sensitive to that.

Adjustment

Facilitator: The problem for us in choosing a case was the high prevalence of sexual problems in GYN oncology and so we presented two cases, which represent significant contrast. Both patients had colostomies. Ms. B felt that it had completely changed the way she felt about herself. She couldn’t feel attractive with stool in the colostomy bag. She didn’t want to see the bag, although she didn’t really fall into complex patterns of avoidance.

Nurse: Ms. C’s femininity focused completely on sexual intercourse and all of her self-esteem related to that. Her surgeon really worked hard at emphasizing how valuable her contribution was as a mother and homemaker. Her husband had been particularly critical when she’d been out of work postoperatively. Work was therefore identified as something that she could do to be productive, to improve their financial situation and also as a distraction. She still held to the hope that sometime in the future she’d undergo successful reconstructive surgery.

Radiation Oncologist: Ms. C had a lot of fibrosis and I started to suggest that there may be only limited improvement. This was clearly a problem. When I suggested that she explore other forms of intimacy with her partner, she said that that would be okay with her but would be unacceptable to him, and when I asked if they’d consider seeking professional help together, she said that he’d never do that. It’s really helpful to have the partner involved and without that it’s a real handicap.

Social Worker: Ms. C has a very narrow definition of sexuality. Partly that reflects upbringing and education and a response to her husband. She’s quite trusting of the team, mainly in the hope that we’ll fix her. But it has given us an entry to work on some of her self-image. She is a gifted woman but was almost paralyzed when faced with the opportunity of working and felt really threatened that her husband would see her fail. In the end the job really
affirmed her and that has helped to define who she is. The other thing that is striking about her is her dedication to her husband. We wanted her to see beyond her situation. However, it wasn’t only about what he wanted. It was also about how she defined herself. I remember her saying, “How can I be a mother to my sons if I’m not sexually intimate with my husband.” When first diagnosed the primary issue is, “Will I survive?” But with time the effects of treatment, and what they mean comes to the fore. There have been times when we’ve had to acknowledge that she’d rather be dead than alive without a vagina, and that’s been really hard. Although we did the medically necessary thing, the implications, for her, have been devastating. So curing the cancer isn’t the whole story and there’s so much more to keeping her afloat.

**Radiation Oncologist:**

Vaginal dilators are really important for a good outcome in patients who receive radiotherapy for cervical cancer. Most women don’t want to talk about it or they say, “I’m not sexually active. I don’t need to do this.” But dilation is crucial for future sexual function. Compliance is a big issue with dilators.

**Nurse:** We give a lot of advice about lubricants, taking time with foreplay, being gentle. But patients still find them difficult.

**Nurse:** At first women look like they want to jump off the table. But once you know them and you make it clear that it’s important and that you can give them all the time they need, they become comfortable and can talk about these issues.

**Nurse:** It’s so important not to minimize the patient’s perception of the situation. Yet, it’s so tempting to do just that. That’s the easy way to appear to make things better.

**Physician:** One thing that gives us a greater sense of confidence is that we can refer on to therapists if we feel that we are out of our depth. We refer to two sex therapists with very different styles, so patients can be channeled to an appropriate therapist.

**Physician:** There’s been a very helpful paper recently that has, for me, taken some of the hokum out of advising patients. It presented the Swedish experience of therapy for cervical cancer, comparing radiation therapy with surgery with a control group taken from the normal, whatever that is, population. In middle-aged women there were approximately 30% who made love less than once a month. So I tell patients that for sexually active couples, there’s a huge span to what is normal.

**Nurse:** It is difficult for some women after a hysterectomy or more radical surgery to get an orgasmic response. It takes time to relearn that. Just telling a woman that is helpful.

**DISCUSSION**

There are 168 hours in the week and only a fraction of that time is spent in sexual activity. Yet, sexuality has a grip on our minds and our media. Sildenafil (Viagra®) very rapidly became the fastest selling drug of all time [2].

**The exchanges within the rounds suggested that many clinicians feel less skilled in sexual rehabilitation than other aspects of practice.**

**Definition**

Human sexuality encompasses more than the endocrinology and anatomy of gender. Sexuality refers to how genders relate and, for the purpose of this article, is defined as aspects of personality pertaining to sexual orientation, attitudes, beliefs, and behaviors. Sexual health integrates the somatic, intellectual, emotional, and social aspects of being sexual.

Before the Kinsey reports [3] the sexual lives of most people were shaped in a social vacuum and determined to a large extent by tacit dogma, personal experiment and uninformed gossip [4]. Kinsey’s in-depth interviews, conducted in the late 1940s and 1950s, revealed a great deal about the sexual behavior of Americans. He reported that masturbation was nearly universal among men (90% did it); homosexual relations were much more common than previously reported (37% had done it once); premarital relations were common (most college men did it); half of married men had extramarital relations and oral sex was common among educated couples (70%). These findings, and later data regarding females, surprised many people, but immeasurably broadened understanding of “normal” sexual behavior.

Sexuality issues are not emphasized in the curricula of health professions. There are relatively few texts that help educate staff about sexuality. The most comprehensive textbook of sexuality is Bancroft’s *Human Sexuality and Its Problems* [5], and the British Medical Journal recently published a series of articles on sexuality: ABC of Sexual Health [6]. However, as reflected in the rounds, the busy professional typically develops a repertoire of counseling skills that reflects personal practice and prejudice. Sexuality is intrinsic to being human. All individuals have a sexual identity and sexual value system, which impact how they...
view the world around them [7]. It is inevitable that what we believe, experience, and act on impacts who we are.

Human sexuality is shrouded in myth. The four most insidious myths are: A) sexuality can’t be understood; “it’s a mystery;” B) the opposite extreme; Love is “natural,” it’s simple and doesn’t require any thought or effort; C) once it goes it’s gone, and D) our personal worth is solely dependent on how much sex appeal we possess.

**Cancer and Sexuality: Collision**

Cancer treatments often cause physical and psychological disruptions to sexual health [8]. Cancer’s threat to one’s sexuality may range from disfigurement, infertility, and impotence to fatigue and alopecia. The existential vulnerability caused by a diagnosis of cancer changes patients’ views of themselves and their relationships with others [9]. Cancer compounds the fatigue and distraction that blunts sexual arousal among healthy partners. Psychological concerns have a profound effect on sexual confidence, which is strongly influenced by our emotions, thought patterns, beliefs, and values [10]. Social issues, diseases, and drugs all affect libido.

Sexual arousal is dependent on the physiological interplay of three overlapping systems: the nervous system, vascular system, and endocrine system. Sexual pleasure also involves the thoughts and feelings evoked during sexual encounters. Masters and Johnson described the human sexual response cycle: arousal, plateau, orgasm, and resolution. Each stage builds incrementally toward orgasmic release. Following orgasm there is a period of resolution in which the capacity for arousal is blocked. Masters and Johnson found that the sexual response cycle was identical for homosexuals and heterosexuals [11]. Within the sexual arousal circuit, there are three important potential break points. The first is physical discomfort. The second, in the emotional arena, is insecurity over image, fear of failure, pressure to perform, unresolved conflict, or undisclosed resentment or guilt are potentially the most powerful blocks. The third is mental “preoccupation,” with either intrusive distractions or by being an anxious spectator of the event.

Bergmark et al. reported a well-controlled anonymous questionnaire surveying women with a history of early-stage cervical cancer aged 26 to 80 years treated in Sweden between 1991 and 1992 [12]. A total of 167 of 247 women with a history of cancer (68%) and 236 of 330 controls (72%) reported that they had regular vaginal intercourse. Twenty-six percent of the women who had cancer reported moderate to severe distress due to vaginal changes, compared with 8% of the women in the control group. The frequency of orgasms and orgasmic pleasure were similar in the two groups. Typically surgery is advocated in younger patients with cervical cancer smaller than 4 cm, with the expectation of lesser disruption of sexual function. In age-matched groups within this study, little difference was observed between surgery and irradiation.

One influential prospective study of 279 men with early prostate cancer appeared to show greater sexual dysfunction and urinary incontinence in the year following radical prostatectomy than after radiotherapy [1]. However, inadequate erections were present in 35% and 42% of men before treatment with surgery or radiotherapy, respectively. Impotence was almost universal three months after surgery, although improved with time in contrast to external-beam radiotherapy, which in the short-term was associated with more bowel and bladder dysfunction and later, increasing impotence.

**Cancer and Sexuality: Dialogue**

In dealing with a patient who is facing a critical junction in both their health and sexuality, the caregiver must begin by attempting to understand the patient’s expectations, premorbid lifestyle, and attitudes towards sex, and the relationship with the current sexual partner(s). A sexual history should define the problem as the patient sees it. It should encompass both physical and psychological problems, establishing what exacerbates or ameliorates these and how they impact relationships. There should be an active screen for anxiety, guilt, and anger that have not been expressed. Every attempt should be made to make the patient comfortable in a supportive environment that allows the expression of concerns and fears, and communicates a sense of confidence that problems can be addressed.

Health care professionals have a duty to assess and educate. Sensitive issues like sexuality require more than an informed approach. Sharing information interactively allows patients to assess whether they can build a relationship of trust with their doctor [13]. Patients often have unvoiced concerns and agendas, and the social and psychological context of the medical dilemma profoundly influences how patients cope. Indeed, under stress, both staff and patients may limit how much information is exchanged [14]. In a recent study that investigated the use of sexual activity questionnaires in gynecological clinical trials, women were supportive of the research and did not find the questionnaire intrusive [15].
The issues raised in the cases presented in these two Schwartz Center Rounds focus on issues associated with genital cancers. These individuals highly valued conventional sexual intercourse. The exchanges within the rounds suggested that many clinicians feel less skilled in sexual rehabilitation than other aspects of practice. The cases reinforce the need to listen and hear the expressed concerns of the patient, his/her partner and those they hold as a couple. Exploration with each person individually, followed by meeting as a couple, can facilitate a fuller understanding of each person’s position. This approach may be particularly important when sexual pleasure is unsatisfying or sought outside the primary relationship. Age, developmental level, goals, and gender preferences influence what information is relevant. Individuals without a current partner are no less concerned about sexuality than others, but may have their needs overlooked. Health care providers need to be aware of their own biases and sexual value system.

The PLISSIT Model

The PLISSIT model of counseling provides a framework for sexual assessment and rehabilitation in cancer care [16]. The four levels: Permission, Limited Information, Specific Suggestions, and Intensive Therapy can be used to a degree that reflects the clinician’s knowledge and experience.

Permission giving legitimizes sexual concerns. The clinician may find Woods’ assessment questions helpful at this level [17]:

- Has this condition affected the way you feel about yourself as a man/woman?
- Has this condition interfered with your being a husband/wife/father/partner?
- Has this condition affected your ability to perform sexually?

These questions give individuals permission to have sexual concerns in the presence of a potentially life-threatening illness, and the person is invited to disclose issues of concern.

Limited information is needed to supplement and address information the patient or partner is lacking; information, for example, about lubricants, contraception or information about sperm banking. Myths and misconceptions are addressed and gentle reeducation offered. The clinician preempts difficulties by giving a description of the expected impact of the disease or the proposed treatment options.

Specific suggestions might be needed to address certain sexual concerns. The suggestions may be as simple as changing time of day and positioning for intimacy to maximize pleasure when there is discomfort or limited energy, arranging “date nights” or “not going all the way” or other approaches to reestablish relaxed arousal and avoid performance anxiety. The sensate-focus exercises of Masters and Johnson [7], provide similar “homework” to create or recreate a sexual comfort zone. “Sexuality and Cancer,” a booklet providing detailed sexual advice and guidance, is available from the American Cancer Society for men and women with cancer [18, 19]. Others find sexual self-help books or videos helpful. Women receiving pelvic radiation should be taught the use of well-lubricated vaginal dilators to maintain the capacity for vaginal intercourse as well as clinical examinations and smears. Specific suggestions should consider the expected changes and address ways to achieve acceptable sexual function and preserve sexual identity. Alternative pleasurable practices that are acceptable to the patient and partner may be discussed and explored.

Intensive therapy may be required for individuals and couples who are or have had a history of past trauma such as abuse, or a troubled relationship and referral for psychological or sexual therapy is appropriate. Anatomical disruption may require surgical intervention to ameliorate symptoms. It is essential that the clinician be aware of the limitations of his/her skills. Many, but not all, concerns can be addressed by a knowledgeable clinician. Compassionate support is an essential element of holistic care, to which every caregiver can contribute. Beyond that, sexual counseling is effective in reducing long-term morbidity. In a randomized study patients who had received counseling for sexual problems reported significantly less confusion and contradiction within areas of self-perception, and more patients returned to normal vocational and sexual functions during the first year after counseling [20].

Conclusion

Health care workers have privileged access to intimate aspects of patients’ lives. Health care providers, patients, and partners have a diverse range of beliefs and attitudes toward sexuality. It is incumbent upon the health care providers to give patients an opportunity to discuss the issues of sexuality and sexual functioning associated with cancer and its treatment. Sexual dysfunction is common among cancer patients because of anxiety, ill health, and a broad spectrum of specific organic causes. The message has been aptly put: talk about it [21]. Patients often do not volunteer sexual problems and health professionals should
inquire about sexual function. This is often met with relief rather than embarrassment, particularly for those with significant apprehensions and problems.

ACKNOWLEDGMENT

We wish to gratefully acknowledge the patients who have challenged us to air this topic in the Schwartz Rounds.

REFERENCES

18 Schover LR. Sexuality and Cancer: For the man who has cancer and his partner. American Cancer Society, Inc. 1988.
19 Schover LR. Sexuality and Cancer: For the woman who has cancer and her partner. American Cancer Society, Inc. 1988.